[Date]

[Insurance Company Name]
[Attn: Prior Authorization/Appeals Department]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Brain MRI with Contrast
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Claim/Reference Number: [If applicable]

To Whom It May Concern,

I am writing on behalf of [Patient Name] to request formal authorization for a Brain Magnetic Resonance Imaging (MRI) with intravenous contrast (CPT Code: [Insert Code, e.g., 70552]).

Clinical Documentation:
The patient presents with the following symptoms and/or diagnoses:
[List specific symptoms, duration, and severity, e.g., chronic progressive headaches, focal neurological deficits, suspected neoplasm, or demyelinating disease].

Medical Justification for Contrast:
Contrast enhancement is medically necessary for this patient to:
- [Select applicable: Increase sensitivity for detecting small lesions or tumors.]
- [Select applicable: Evaluate the integrity of the blood-brain barrier.]
- [Select applicable: Differentiate between active and chronic inflammatory processes.]
- [Select applicable: Characterize vascular abnormalities or infectious processes.]

Previous Treatments/Diagnostics:
To date, the patient has undergone the following interventions without definitive resolution:
- [List previous medications, physical therapy, or imaging like non-contrast CT/MRI and the results].

In my professional medical opinion, a Brain MRI with contrast is the most appropriate next step to ensure an accurate diagnosis and direct the necessary treatment plan for [Patient Name].

Please contact my office at [Phone Number] if you require additional clinical documentation or have further questions.

Sincerely,

[Physician Name, MD/DO]
[NPI Number]

[Practice Name]
[Phone Number]